

High Mountain Therapy, LLC

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Insurance Form

INSURED

Name of Insured :(PRINT)

Insured's address: _____

Insured's Home Phone: _____ Cell: _____

Business Phone: _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Place of Business: _____

Insured's Health Insurance Plan or program name: _____

Policy #: _____ Group #: _____

Are there any other health benefit plans Yes No

If Yes: Name of Insurance or plan name: _____

PATIENT

Name of Patient/Client: _____

Date of Birth of Patient/Client: _____

Relationship to Insured: _____

Employer or school name of Patient/Client: _____

Name of Primary Care Physician: _____

Phone number of Primary Care Physician: _____

Payment will be made directly to Service Provider

Signature of Patient: _____

Signature of Insured: _____

Dated: _____